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| **NAME:**         | **SIMS:**      |
| **PARENT/GUARDIAN NAME:**         | **PHONE:**      |
| **ADDRESS:**         | **WK PHONE:**      |
| **Email:**         |  |
| **SCHOOL DISTRICT:**      | **SCHOOL:**      |
| **DOB:**      | **AGE:**      | **GRADE:**      |
| EC PROGRAM:      |  |
| **GENDER:** \_\_\_\_\_\_\_\_\_\_\_ | **RACE:** \_\_\_\_\_\_\_\_\_\_\_ |
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| Name of Referring Person:        Signature:         | Date of referral:        |

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| List the strategies/interventions that have been implemented in the classroom prior to this referral (may attach documentation): |
| Is the child on medication? [ ]  No [ ]  YesMedical Concerns/Diagnoses(ex. Has the child been diagnosed with a medical condition, such as vision or hearing loss?):  |

**Please check those items below that further describe your area(s) of concern:**

**COGNITIVE SKILLS**

[ ]  Follows verbal and gestural commands [ ]  Retells/Repeats Stories, Songs

[ ]  Understands cause/effect [ ]  Identifies Body Parts [ ]  Identifies Shapes

[ ]  Identifies Categories (Object, Use) [ ]  Remembers Directions [ ]  Identifies Colors

**BASIC READING SKILLS**

[ ]  Rhyming [ ]  Blends Sounds to Make Words [ ]  Enjoys being read to

[ ]  Identifies Letters of the Alphabet [ ]  Identifies Sounds in Words [ ]  Demonstrates use of books

[ ]  Letter-Sound Correspondence [ ]  Syllabication

**BEGINNING MATH SKILLS**

[ ]  Rote Counting [ ]  One to One Correspondence [ ]  Understands Patterns

[ ]  Quantitative Concepts (size, shape, length) [ ]  Understands More/Less

**FINE MOTOR SKILLS**

[ ]  Use of eating utensils [ ]  Feeds Self [ ]  Pencil Grip

[ ]  Formation of shapes/letters, etc. [ ]  Cutting skills

**GROSS MOTOR SKILLS**

[ ]  Walking, running [ ] Balance [ ]  Ball Skills

[ ]  Using playground equipment [ ] Sitting in chair/circle time

**ADAPTIVE SKILLS**

[ ]  Toilet training [ ]  Feeding [ ]  Bathing/Washing Hands

[ ]  Dressing [ ]  Understands dangerous situations/shows caution

[ ]  Sleep Routines [ ]  Food sensitivity [ ]  Personal Information

**SOCIAL SKILLS**

[ ]  Appropriate behavior in public [ ]  Greets Others [ ]  Engages in Role Play

[ ]  Allows others to participate in play [ ]  Understands & Recognizes Feelings [ ]  Assists others

**EXPRESSIVE COMMUNICATION**

[ ]  Pragmatics (Social language/conversation) [ ]  Provides information

[ ]  Vocabulary/Concepts (# of Words used) [ ]  Names Object & People

[ ]  Participates in Conversation (turn taking) [ ]  Sentence Length

[ ]  Uses Pronouns [ ]  Retells a story

[ ]  Reasoning/Problem Solving (gives answers to problems) [ ] Grammar (syntax;incorrect pronouns)

**RECEPTIVE COMMUNICATION**

[ ]  Auditory Attention Span (blocks out competing auditory information) [ ]  Sequences of Events (nonverbally) [ ]  Follows Directions Promptly [ ]  Understands Directions

[ ]  Auditory Discrimination (discriminates two auditory words/sounds) [ ]  Answers “Wh” questions

[ ]  Auditory Memory (remembers songs/rhymes) [ ]  Understands Negatives

**SPEECH**

[ ] Articulation (correct production of sounds)

[ ] Fluency (stutters/repeats words or syllables, hesitates, prolongs words)

**BEHAVIOR/EMOTIONAL (Extreme or Excessive)**

[ ]  Independent Activity [ ]  Group Activity [ ]  Peer Relationships

[ ]  Attention Span [ ]  Overactive [ ]  Home Relationships

[ ]  Passive/Shy [ ]  Verbally Aggressive [ ]  Unresponsive

[ ]  Withdrawn [ ]  Disruptive [ ]  Physically Aggressive

[ ]  Mood Swings [ ]  Motivation [ ]  Other (specify)

[ ]  Non-Compliant [ ]  Teacher Relationships

MUST comment on areas checked and include frequency and duration:

**HEALTH**

[ ]  Hearing (Specify Concerns)

[ ]  Vision (Specify Concerns)

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| **(District Use Only)** Date of conference held with person making the referral:        Method        Teacher Information:        Review of student record (i.e. attach current grades, attendance record, enrollment gaps, various school enrollments, retention information, State and District-wide Assessment data, etc.):         |
| Based upon a review of all referral information, potential areas of disability to evaluate are:[ ]  0500-D/B [ ]  0505 -ED [ ]  0510-CD [ ]  0515-HL [ ]  0525-SLD [ ]  0530-MD [ ]  0535-OI [ ]  0540 –VL [ ]  0545 –D [ ]  0550-S/L [ ]  0555-OHI [ ]  0560-A [ ]  0565-TBI [ ]  0570-DDRefer to the South Dakota Eligibility Guide for testing areas required to determine eligibility. |
| Parent Contacted: (Date)       Parent information:        If this was a parent referral, and the district determines evaluation is **not** necessary, Prior Notice was sent to parents: (Date)        |